UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
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MERTYLIN CARROLL,

Plaintiff,

-against-

KENNETH S. APFEL, Commissioner of Social Security Administration,

Defendant.

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97 CV 2537

MEMORANDUM AND ORDER

MERTYLIN CARROLL
904 Schenectady Avenue, Apt. 1R
Brooklyn, NY 11203
plaintiff pro se.

ZACHARY W. CARTER, United States Attorney
(Leslie A. Brodsky, of counsel)
One Pierrepont Plaza, 14th Fl.
Brooklyn, New York 11201
for defendant.

NICKERSON, District Judge:

Plaintiff pro se brought this action to review a final decision of the Commissioner of Social Security denying plaintiff disability insurance benefits. Plaintiff has been found disabled as of March 26, 1990

and therefore eligible for supplemental security income. That matter is not in issue in this case. The only question is whether plaintiff was disabled before June 30, 1980, the date her insured status expired. This court has jurisdiction under 42 U.S.C. § 405(g).

The Commissioner moves and plaintiff cross-moves for judgment on the pleadings.

I

This case has a long history. On March 26, 1990 plaintiff filed an application for both disability insurance benefits and supplemental security income. On July 5, 1990 the Commissioner denied the application and denied reconsideration on August 30, 1990.

On plaintiff's appeal an Administrative Law Judge, on February 7, 1991, granted the application for supplemental security benefits as of March 26, 1990 but denied disability insurance benefits. The Appeals Council denied plaintiff's application for review.

Plaintiff then brought action in this court. On December 31, 1992, by stipulation of the parties, the

court remanded the case for further administrative proceedings pursuant to the settlement agreement in Stieberger v. Sullivan, 792 F. Supp. 1376 (S.D.N.Y. 1992).

After a supplemental hearing an Administrative Law Judge found on August 11, 1993 that plaintiff was not disabled on or before the date of June 30, 1980, when her insured status ran out. The Appeals Council denied review.

The Administrative Law Judge's decision discussed various medical reports from several doctors including two reports from Dr. Aubrey Griffith dated September 10 and October 21, 1976. Plaintiff had testified that she was treated by Dr. Griffith from 1976 until 1986, but no evidence of that alleged treatment was in the record. The Administrative Law Judge observed that Dr. Griffith had not responded to a subpoena for production of his office records.

Nevertheless, the Administrative Law Judge concluded that plaintiff was not disabled on or before

June 30, 1980. He found that plaintiff had an injured left knee, had not engaged in substantial gainful activity since August 1975, and met the disability insured status requirements through June 30, 1980. But he found her allegations of pain and functional limitations not credible because there was a paucity of medical treatment and she did not have an impairment significantly limiting her ability to perform basic work-related activities before June 30, 1980.

On January 20, 1995 this court remanded the case, holding that the Administrative Law Judge had an obligation to assist a pro se claimant such as plaintiff to develop the record. The court directed the Administrative Law Judge to obtain Dr. Griffith's records by subpoena, and directed plaintiff to try to get them or ask Dr. Griffith to testify.

On July 10, 1996 a further hearing was held before a different Administrative Law Judge who, on September 16, 1996, concluded that plaintiff was not disabled between August 18, 1975, when the alleged disability

first occurred, through June 30, 1980. The Appeals Council denied plaintiff's request for review, and this action followed.

The Administrative Law Judge found that plaintiff met the insured status requirements between August 18, 1975 and June 30, 1980, that she had not engaged in substantial gainful activity since August 18, 1975, that the medical evidence showed she suffered from injuries to her right ankle and left knee, that plaintiff did not have any listed impairment, and that her claims of pain were not credible or supported by medical evidence. He concluded that she had the residual functional capacity to perform the physical exerti n requirements of work, except for lifting/carrying over ten to twenty pounds and standing/walking over six hours in a work day, and that, although unable to perform her past work as a nurse's aide, she had the capacity to perform light and sedentary work.

II

Plaintiff was born on February, 13, 1932 and attended twelve years of school in Jamaica. She is literate in English. She completed a nurse's aide training course in 1968 and worked as a nurse's aide from 1956 to 1975. She testified that she had an accident in July 1975 injuring her right ankle. On August 18, 1975 plaintiff injured her left knee while helping lift a patient at Kings Highway Hospital. She said that she suffered persistent swelling and pain, and had difficulty walking.

She was examined on August 21 and again on October 10, 1975 by Dr. Julius Schoenfeld, an emergency room physician at the Kings Highway Hospital. He concluded that her condition was "orthopedically negative" but recommended that she not perform work activities requiring heavy lifting or bending because she had a history of sciatica.

On September 3, 1975 Dr. Bernard Levowitz, who previously treated plaintiff for a neuroma requiring

herniorrhaphy (surgical repair of a hernia), examined her. In a September 19, 1975 report he stated that she was capable of working full-time. On November 26, 1975 he reported that she recovered fully and could carry out the usual duties as a nurse's aide without restrictions.

On January 19, 1976 Dr. Leo J. Koven, a consultative examiner, saw plaintiff. He concluded that her legs were capable of a full range of motion, and that there were no motor, sensory or reflex changes. He stated that the only possible finding of consequence was the presence of hypermobility of the patella bilaterally. He determined that if plaintiff had completely recovered from her sciatica condition, she could perform the duties of a nurse's aide, including bending, lifting, and pulling.

Dr. Jack Kapland, a consultative examiner, saw plaintiff on May 26, 1976. She complained of pain on complete flexion of the left knee, but there was no crepitus or excess mobility of the knee. She had no

apparent limp, no tissue swelling or increase in joint fluid, and no atrophy or loss of muscle tone, and had normal ranges of motion in the ankle. An x-ray of the left knee showed no evidence of fracture or dislocation.

Dr. Kapland said that his examination did not reveal any residual objective findings attributable to the incidents of July 5 or August 18 1975 and that she was not disabled but was capable of pursuing her work as a nurse's aide.

On June 14, 1976 Dr. Patricia Harrow, a Workmen's Compensation Board examiner, saw plaintiff. Plaintiff was complaining of intermittent sharp pains in her left knee with buckling and locking of the joint. Dr. Harrow noted some atrophy of plaintiff's left quadriceps, calf muscles, and a very mild defect of the knee's flexion-extension due to pain. The doctor concluded that plaintiff was partially disabled due to her left knee injury but found no disability in the right ankle.

Dr. Stanley Soren began treating plaintiff on February 13, 1976. He filled in a series of reports on forms from the Workmen's Compensation Board. The first report, dated February 19, 1976, states that x-ray's of the right ankle and left knee were negative for fractures, and refers to "contusion of right ankle" and "degenerative torn medial meniscus left knee." The doctor placed a question mark in the "no" box in answer to the question "Is patient working?" He marked an x in the "yes" box asking "Is patient disabled?" He also marked an x in the "yes" box asking the question "May the injury result in permanent restriction, total or partial loss of function of a part or member, or perman nt facial, head or neck disfigurement?" Dr. Soren also requested "authorization for arthrotomy and meniscectomy of left knee if necessary."

On a form dated March 23, 1976 Dr. Soren said that although plaintiff's knee buckled, it did not cause her to fall, and noted that an arthrogram of the knee was normal. In the box asking "Resume limited work of any

kind?", the doctor filled in "fit for lite [sic] duty."

On a form dated April 23, 1976 Dr. Soren again marked "fit for lite [sic] duty" in response to the question, "Resume limited work of any kind?" The same form, this time dated May 10, 1976, contains Dr. Soren's entries plaintiff "on last examination feeling better," "fit for duty," and "no return necessary."

On the form dated September 13, 1976, referring to an examination of August 30, 1976, Dr. Soren filled in "left knee still bothers her. Pain Walking. Tender grating left knee anterior medial, synovitis." In the box "Nature of treatment" he filled in "white knee cage."

On the form dated December 1, 1976 Dr. Soren filled in "On examination of 11/30/76, there was still pain of the ankle and left knee. Tenderness medial point line of left knee." He also requested "authorization for medial menisectomy and arthrotomy left knee." He requested the same authorization in his final report as to plaintiff dated March 9, 1977.

Pursuant to a subpoena, Dr. Aubrey Griffith submitted all available records pertaining to his treatment of plaintiff. While plaintiff testified at the hearing of June 8, 1993 that she saw Dr. Griffith "all the way into the 80's...until 1986," there are no records referring to any treatment by Dr. Griffith of plaintiff between November 1976 and some time in 1983.

Dr. Griffith completed four reports on forms from the Workmen's Compensation Board. The first report is dated June 8, 1976 and says that "patient still complains of pain in leg." The doctor marked an x in the "no" box asking the question "Is patient working?" In response to the question "Is patient disabled?", Dr. Griffith marked an x in the "no" box. The doctor placed question marks in the boxes asking "If treatment is continuing, estimate its duration," and "May the injury result in permanent restriction, total or partial loss of function of a part or member, or permanent facial, head or neck disfigurement?"

On two forms dated August 10 and September 10 1976

the doctor again stated that "patient still complains of pain in leg." In the boxes asking "Resume limited work of any kind?" and "Resume regular work?" he wrote "unknown." Dr. Griffith marked an x in the "no" box asking the question "Is patient working?" In response to the statement "If treatment is continuing, estimate its probable duration," Dr. Griffith wrote "unknown."

On the last form dated October 21, 1976 Dr. Griffith filled in "sprain left knee. Probable chronic deranged mensicus. Patient still complains of pain. Recent increase." In the box "Nature of treatment" Dr. Griffith filled in "Observation. Depo Medrol, rest, heat, x-ray, Naprosyn tabs." He again filled in "unknown" to the questions "Resume limited work of any kind?" and "Resume regular work?"

III

The Commissioner's findings of fact are conclusive if supported by substantial evidence, even if there is substantial evidence supporting the plaintiff's position. See Jones v. Sullivan, 949 F.2d 57, 59 (2d

Cir. 1991). The court must also determine whether the claimant has had a "full hearing" as required by the regulations. Cruz v. Sullivan, 912 F.2d 8, 11 (2d Cir. 1990).

An individual shall be considered disabled if she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than 12 months. See 42 U.S.C. § 423(d)(1)(A).

The physical or mental impairment must be so severe that the individual "is not only unable to do his previous work but cannot, considering his age, educat on, and work experience, engage in any other kind of substantial gainful work which exists in the national economy." 42 U.S.C. § 423 (d)(2)(A).

Although plaintiff was unable to perform her past work as a nurse's aide, the Administrative Law Judge determined that she had the residual functional capacity to perform light and sedentary work. 20

C.F.R. 404.1567(a),(b). This determination is supported by substantial evidence.

Based on his examinations in August and October 1975 Dr. Schoenfeld concluded that plaintiff should not perform her usual duties as a nurse's aide but said that plaintiff was capable of performing work not including lifting or bending. In October 1975 he found that her orthopedic examination was entirely negative, and that plaintiff made no complaints.

While Dr. Soren in his February 19, 1976 report diagnosed plaintiff with a degenerative or torn medial meniscus of the left knee, a later arthrogram of the knee was completely normal. On March 23, 1976 he decided she was capable of performing "lite [sic] duty." In April 1976 Dr. Soren again said that plaintiff was "fit for lite [sic] duty." Less than 12 months after her injury, Dr. Soren reported on May 10, 1976 that plaintiff's left knee was better, and she was fit for duty. He also reported that no further visits were necessary.

On January 19, 1976, five months after her accident, Dr. Leo Koven concluded that plaintiff's legs were capable of a full range of motion and, if she had completely recovered from her sciatica, could perform all of her job functions.

Dr. Kapland said that his examination of May 26, 1976 did not reveal any residual objective findings attributable to plaintiff's accident. He reported that x-rays taken in May were completely negative, and that plaintiff was not disabled.

In June 1976 Dr. Patricia Harrow said that plaintiff's left knee was partially disabled but concluded that her condition was too early for final adjustment. The doctor found that plaintiff did not have a disability in her right ankle.

On June 8, 1976 Dr. Griffith said that plaintiff was not disabled. Although the doctor noted in August and September 1976 plaintiff's complaints of pain in her ankle and leg, he only wrote "observation" in the "Nature of treatment" box.

The Administrative Law Judge, who gave plaintiff a full hearing, concluded that even taking plaintiff's allegations of pain and disability "to the extreme," there was no evidence that plaintiff could not perform at least a full range of sedentary work. This conclusion is fully justified by the record.

The determination by the defendant is affirmed, and the complaint is dismissed. So ordered.

Dated: Brooklyn, New York
June 25, 1998

Eugene H. Nickerson

Eugene H. Nickerson, U.S.D.J.